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Response to Intervention and Positive Behavior Support

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Special education in the United States emerged as an extension of the medical model that experienced explosive growth in the decades of the fifties and sixties (cf. Sailor & Guess, 1980). The construct of disability (or “handicap” as it was largely described in that period) placed the locus of educational impairment squarely on the individual. Failure to progress educationally or developmentally along expected age norms was considered the result of a quasi-disease state. This was during the testing movement, when the fields of psychiatry and psychology were growing rapidly. Thus, when a pattern of deficit in educational progress was determined, the student would be referred for diagnostic testing. Analysis of test results would then determine a likely category of disability, and a prescription would result, often in the form of referral to special education, usually to a special class formed to address the needs of students in that category.

More recently, a different logic model has begun to emerge for providing services and supports to students who fail to progress as expected in the general curriculum, one that stands in contrast to the extant medical model and challenges it as having the potential to be a better service model. Response to intervention (RTI) is the prevalent term for this logic model, and as of this writing, it is gaining rapid momentum across all aspects of preschool through 12-grade education in America.
In this chapter, we trace the origins of RTI as a community mental health prevention model and examine its emergence into service eligibility determination in special education. We consider some current definitions of RTI and focus on the alignment of RTI and positive behavior support (PBS) as two sides of the same coin (or “pyramid,” in this case, as we shall describe): academics and behavior. We examine the emerging model with particular attention to its linkages with PBS research. We describe emerging policy frameworks that are helping to drive the RTI agenda and consider some of the cultural issues in its application. Finally, we examine emerging personnel preparation requirements concerning implementation of RTI and briefly examine current trends in RTI research and practice in education.

**HISTORY OF RESPONSE TO INTERVENTION**

First, through describing an exemplar student going through the two different procedures for identification, we consider the contrast evident in the two logic models. Susie is a first grader who is falling behind her classmates in reading. Her teacher notices that she regularly gets stuck on the early passages and seems to be getting increasingly frustrated. Furthermore, her teacher notes that Susie has been scribbling on and otherwise defacing her reader, in some cases tearing out pages. Individual attention does not seem to be resulting in improvement, and the teacher finds herself calling on Susie less and less frequently to avoid slowing the progress of the other students. Finally, Susie is referred to the school psychologist for psychological and psychoeducational testing to see if there is a disability present that would explain Susie’s lack of progress. On the basis of the psychologists’ interpretation of IQ test data and other test results, Susie is diagnosed as having a learning disability (LD) and is assigned, through the individual educational plan (IEP) process, to a “resource room,” a special class for students with LD.

Now, consider an RTI logic model applied to Susie’s case that exemplifies just one possible model of RTI implementation. In the fall, Susie would be screened with all of the other students. If Susie falls below a certain criterion, she will begin receiving extra services beyond the general curriculum/regular class instruction that she will continue to receive. This extra assistance will likely be provided in a small-group setting, with other students who have similar academic needs as determined by the screening and teacher report. Susie’s progress will be monitored, perhaps once a week, with a curriculum-based measure (CBM), and if she is not progressing as quickly or as greatly as has been set as a benchmark/criterion after a reasonable amount of time, a specialized team will examine her progress-monitoring results, screening results, and teacher observations and will make recommendations for intensive and/or individualized instruction to be delivered for a specified intensity, duration, and frequency. If Susie does not meet the criterion set for her at that point, the 60-day timeline begins for special education evaluation.

First, we notice that emphasis is placed on identifying and describing Susie’s specific problem rather than on quickly arriving at a disability